DOE F 350.3
(08-02)

OMB Control No: 1910-5120
Expiration Date: 8/31/05

Request for Review by Physician Panel
Energy Employees Occupational Illness Compensation Program Act (EEOICPA)
Part D DOE State Workers' Compensation Assistance Program

U.S. Department of Energy
Office of Environment, Safety and Health
Office of Worker Advocacy

SURVIVOR APPLICATON

For assistance in completing this application, please refer to the attached Instructions for Completing the Request for Review by Physician Panels-- Survivor Application. DO NOT FILL IN SHADED AREAS

SURVIVOR INFORMATION

Official Use Only. To be completed by HQ or RC
OWA_____ DOL_____

1. Name _____
   Last First M.I

2. Address _____

   _____

3. Telephone (Day) _____ (Evening) _____

4. E mail Address (optional) _____

5. Social Security Number _____–_____ –_____

6. Relationship to the Deceased _____

7. Additional Survivors _____ Relationship _____
   (i.e. children)

   _____ _____

   _____ _____

DECEASED EMPLOYMENT INFORMATION

8. Name_____
   Last First Middle initial

   _____
   Former Name (i.e., maiden name/legal name change/other)

9. Date of Birth _____/_____/_____

10. Date of Death _____/_____/_____

11. Social Security Number _____-_____-_____

- ❑ A copy of the death certificate has been attached.
- ❑ A copy of the medical examiner's report is attached (if available).
- ❑ A copy of the coroner's report is attached (if available).

EMPLOYMENT INFORMATION

12. Please complete and attach the *DOE Work History for Claim Under Energy Employees Occupational Illness Compensation Program Act* (DOE Form 350.6).

    ❑ The DOE Work History Form has been completed and attached.

ILLNESS INFORMATION

13. What illness did the deceased have diagnosed by a physician, that you believe was related to his or her work at a DOE facility? (If claiming multiple illnesses, please use continuation sheet.)

    Illness: _____ Date of Diagnosis: _____

14. Physician or healthcare provider that diagnosed the illness. (The *Authorization for Release of Information DOE Form 350.4* must be completed and attached for each physician or healthcare provider listed.) **If necessary, use additional sheets of paper**.

Name of Physician or Healthcare Provider	Address:	Phone No.:
_____	_____	_____
_____	_____	_____
_____	_____	_____

    ❑ An Authorization for Release of Information has been completed and attached for each physician or healthcare provider.

15. To your knowledge, if the deceased participated in medical screening through a DOE-sponsored Former Worker Program, please check the appropriate program:
    - ❑ No, did not participate in former worker program
    - ❑ Amchitka Workers Medical Surveillance
    - ❑ Hanford Building Trades Medical Surveillance
    - ❑ University of Washington Former Hanford Workers
    - ❑ INEEL, Medical Screening Program
    - ❑ Iowa Army Ammunition Plant Former Workers
    - ❑ Los Alamos National Lab Former Workers
    - ❑ Nevada Test Site Former Worker Program
    - ❑ Oak Ridge Former Construction Worker Medical Surveillance
    - ❑ Oak Ridge K-25 Production Worker Medical Screening Program
    - ❑ Paducah Medical Screening Program
    - ❑ Portsmouth Medical Screening Program
    - ❑ Rocky Flats Former Worker Program
    - ❑ Augusta Building Trades Medical Surveillance Program
    - ❑ Savannah River Production Former Workers Program

ADDITIONAL INFORMATION

16. Have you filed a claim under the Department of Labor Federal program for any of the following?

- ❑ Beryllium Disease
- ❑ Cancer (type of cancer:_____)
- ❑ Silicosis
- ❑ Other: _____
- ❑ No, I have not filed a claim under the Department of Labor Federal program.
- ❑ If yes, please provide the DOL claim number if known: _____

17. To your knowledge has a State worker's compensation claim been filed for any illness being claimed:

❑ Yes ❑ No

If yes, please complete the following for each illness claimed (use additional paper if necessary)

Illness: _____

State: _____

Outcome: ❑ accepted ❑ denied ❑ pending

Date: _____

18. We are providing here, an opportunity for you to authorize the Office of Worker Advocacy staff to discuss your claim with individuals you wish to name. To maintain the confidentiality of your case, if you wish to allow an individual to contact the OWA on your behalf, please identify them by name below and, for identification purposes, list the maiden name of the individual's mother.

Last	First	Mother's maiden name
Last	First	Mother's maiden name

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CLAIMANT DECLARATION

I hereby make a claim for assistance under Part D- of the Energy Employees Occupational Illness Compensation Program Act and affirm that the information I have provided on this form is true. I understand disclosure of this information is voluntary, but failure to provide necessary information may involve delay in processing my claim or may result in a denial of my claim.

The information submitted is authorized to be collected by the Department of Energy, Office of Worker Advocacy, by the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) of 2000.

The principal purpose for which these records are to be used is to help determine my eligibility for benefits under the EEOICPA by verifying medical condition(s) or exposure(s) to radiological or toxic substances during an employment time period that is covered under the EEOICPA. Other uses which may be made of this information are the following: the employment verification, medical, exposure and other additional records may be retained in my claims file and may be released to any person whose responsibilities include processing of my claim .

I hereby attest that the records, copies of records and or other information I have submitted to the Department of Energy, Office of Worker Advocacy are authentic. I attest that these records have not been altered, and no materials have been removed from these records.

Furthermore, I authorize any physician or hospital or any other institution, corporation, or government agency to furnish any desired information to the U.S. Department of Energy, Office of Worker Advocacy.

I understand that any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain assistance by the Department of Energy, Office of Worker Advocacy, or who knowingly accepts assistance to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

_____ _____

Claimant Signature Date

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INSTRUCTIONS

FOR COMPLETING THE REQUEST FOR REVIEW BY PHYSICIAN PANEL, ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION ACT (EEOICPA)—**SURVIVOR APPLICATION**

The following instructions are provided to assist you in completing **the Request for Review by Physician Panels Survivor Application**. Please complete this form to the best of your ability. Any omission of information could cause a delay in the review of your claim. A signature is required to submit your claim.

OMB Burden Disclosure Statement

Public reporting burden for this collection of information is estimated to average 1 hour 18 minutes, including time for reviewing instructions, searching existing data sources, gathering data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Records and Business Management (IM-11), U.S. Department of Energy (OMB 1910-5120), Washington, D.C. 20585 and to the Office of Management and Budget (OMB), Paperwork Reduction Project (OMB 1910-5120), Washington D.C. 20502. **Do not mail you application to this address, see section Claimant Declaration for mailing address.**

Survivor Information

1. Fill in your name (last, first, middle initial). If you have used any other name, please include that in the space provided.

2. Provide your complete address.

3. Provide a telephone number where you can be reached during both day and evening hours.

4. Provide e-mail address if applicable.

5. Provide your Social Security Number.

6. Provide your relationship to the deceased. (Attach a copy of marriage license, birth certificate, or adoption papers demonstrating proof of relationship to the deceased.)

7. Indicate whether there are additional survivors. If there are additional survivors, please provide their name and relationship to the deceased.

Deceased Employee Information

8. Provide the name (last, first, middle initial) of the deceased employee. If any other names were used, please include that information in the space provided.

9. Provide the date of birth of the deceased.

10. Provide the date of death. A copy of the death certificate must be attached.

11. Provide the Social Security Number of the deceased.

Employment Information for the Deceased

12. Included in this package is the *DOE Work History for Claim Under Energy Employees Occupational Illness Compensation Program Act (DOE F 350.6*). Please complete this form to the best of your ability including all information relative to the employment history of the deceased either for or at a Department of Energy facility.

Illness Information

13. Please list the following: the diagnosed illness that you believe was a result of their work at a DOE facility, the date of the diagnosed illness, and the name of the physician or clinic that made the diagnosis. If there are multiple illnesses, please list the information on an additional sheet of paper and attach to this request.

    - Note: You must complete, sign, and attach an *Authorization for Release of Information (DOE Form 350.4)* for each physician or clinic listed above, so that the Office of Worker Advocacy can obtain records relevant to your application. You must also fill out this form if you participated in a Former Worker Program or applied to the Department of Labor. The signature must be original, photocopies will not be accepted.

14. Please indicate if you believe the cause of death was caused by the illness.

15. If the deceased had received a medical screening through a DOE-sponsored Former Worker Program, check the appropriate box.

Additional Information

16. If you have filed a claim as a survivor for Federal compensation with the Department of Labor, please check the appropriate box. If you submitted a claim as a survivor for a disease/illness other than Beryllium Disease, Cancer, or Silicosis, please check the "Other" box and write in the disease/illness for which you submitted a claim.

17. If you have filed a State worker's compensation claim for survivor benefits for an illness that you have listed in #13, please indicate the illness, the State in which you filed the claim, the outcome, and the date the claim was filed.

18. To protect your confidentiality, the Office of Worker Advocacy will not discuss your file unless the applicant of primary survivor gives the Office permission. Therefore, please list all individuals and their relationship to you whom you authorize to discuss your claim with OWA.

Claimant Declaration

A signature and date is required for this claim to be reviewed. Please submit your claim through the your local resource center or through the following address:

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U.S. Department of Energy
Office of Environment, Safety and Health
Office of Worker Advocacy (EH-8)
L'Enfant Plaza Suite 800
1000 Independence Avenue, SW
Washington, DC 20585

Attn: Claims Processing/application

If you have questions, please contact your local Resource Center or call the EEOICPA Hotline at 1-877-447-9756.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Energy Employees Occupational Illness Compensation Program Act-Part D (P.L. 106-398) (EEOICPA) authorizes the collection of the information on this form; (2) The Office of Worker Advocacy of the U.S. Department of Energy, which administers the program, may disclose information to Federal agencies or private entities which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider other relevant matters; this is the principal purpose for which this information is collected; (3) information may be disclosed to federal agencies or entities whose mission entails reviewing or managing workers' compensation claims or administering other benefits programs; (4) information may be disclosed, as a routine use, to physicians and other health care providers for use in providing treatment or medical rehabilitation, making evaluations for the Office of Worker Advocacy, and for other purposes related to the medical management of the claim; (5) furnishing this information is voluntary, but failure to disclose all requested information may delay the processing of the claim or may result in an unfavorable decision. This notice applies to all forms requesting information that you might receive from the Office of Worker Advocacy in connection with the processing and adjudication of the claim you filed under the EEIOCPA.